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Montana Health and Economic Livelihood Partnership (HELP) Program

Evidence of Coverage

Effective January 1, 2016

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The HELP Coverage Group agrees to make payment for the medical, mental health, surgical, Hospital, and Pharmacy services named in this Evidence of Coverage (EOC) subject to the following conditions:

1. All statements made in the Montana Health and Economic Livelihood Partnership (HELP) Program Application for eligibility must be true and correct.

2. Payments by the HELP Coverage Group will be subject to the terms, conditions, and limitations of this EOC.

3. Payment will only be made for services that are provided to the Participant after the Effective Date of this EOC and before the date on which this Evidence of Coverage terminates.

ARTICLE ONE – DEFINITIONS

This Article defines certain words used throughout this Evidence of Coverage. These words will be capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

- Identified by time and place of occurrence; and
- Identifiable by Participant or part of the body affected; and
- Caused by a specific event on a single day.

Some examples are:

- Fracture or dislocation;
- Sprain or strain;
- Abrasion, laceration;
- Contusion;
- Embedded foreign body;
- Burns; and
- Concussion.

ADMISSION CERTIFICATION FOR EMERGENCY CARE AND MATERNITY CARE

Notification to the Claim Administrator by the Participant, or family participant, of an emergency Inpatient admission or an Inpatient admission related to pregnancy, including pre-term labor, complications of pregnancy, or delivery.

ADVANCE BENEFIT NOTIFICATION (ABN)

Refers to the process in which a professional provider informs the Participant that a service is not medically necessary in accordance with the Claim Administrator Medical Policy prior to having the service performed, and requests the Participant sign an ABN to accept responsibility for payment if the Participant wishes to proceed with the service. The Participant is only responsible for the payment of the Non-medically necessary or non-covered service if an ABN has been signed by the Participant or the Participant's authorized representative.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana (BCBSMT) to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or
2. Diagnosis-related group (DRGs) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level

of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by BCBSMT to a nonparticipating providers under the DRG system can be considerably less than the nonparticipating providers' billed charge; or

3. Billed Charge is the amount billed by the provider; or
4. Case Rate methodology is an all inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by BCBSMT to nonparticipating providers under the Case Rate system can be considerably less than the nonparticipating providers' billed charge; or
5. Per Diem methodology is an all inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by BCBSMT to nonparticipating providers under the Per Diem system can be considerably less than the nonparticipating providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service, For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by BCBSMT to nonparticipating providers under the Flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.

AMBULANCE

A privately or publicly owned motor vehicle or aircraft that is maintained and used for the emergency transport of patients that is licensed and further defined in 50-6-302, MCA.

APPROVED CLINICAL TRIAL

Approved clinical trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

- The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
- A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
- A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or

- The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

BENEFIT

Services, supplies and medications that are provided to a Participant and covered in this Evidence of Coverage (EOC) as a Covered Medical Expense.

BENEFIT PERIOD

The Benefit Period is January 1 through December 31. If a Participant's Effective Date is after January 1, the Participant's Benefit Period begins with the Effective Date and ends December 31.

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)

BCBSMT, a Division of Health Care Services Corporation, a mutual legal reserve company, is a Claim Administrator for the Department.

CARDIAC REHABILITATION THERAPY

Medically supervised program that helps improve the health and well-being of people who have heart problems.

CARE MANAGEMENT

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including covered providers, BCBSMT, and other resources to work with Participants to promote quality, cost-effective care.

CLAIM ADMINISTRATORS

Claim Administrator means a Department contractor that provides consulting services to the Department and other administrative functions, including the processing and payment of claims. The Claim Administrators provide administrative duties only.

COINSURANCE

The percentage of Covered Medical Expenses and Allowable Fee for services payable by the Participant.

COMPLAINT

A verbal or written communication by the Participant or his or her authorized representative that identifies an adverse action by the Department.

CONCURRENT CARE

- Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or
- Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant's condition requires the skills of separate Physicians.

CONTINUED STAY REVIEW

BCBSMT's review of an Inpatient stay beyond what was initially certified to assure that the setting and the level of care continues to be the most appropriate for the Participant's condition.

COPAYMENT

The specific dollar amount of Covered Medical Expenses and Allowable Fees for services payable by the Participant.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary medical and Dental services and supplies that are:

- Covered under this EOC; and
- In accordance with the Medical Policy; and
- Provided to Participants by and/or ordered by a Participating Provider for the diagnosis or treatment of active Illness or injury or in providing maternity care.

DENTAL

Covered Dental services delivered by Dental providers in the HELP Dental Network.

DEPARTMENT (DPHHS)

The Department of Public Health and Human Services, State of Montana (DPHHS).

DISENROLLMENT

The process of ending the Participant's Participantship in the HELP Coverage Group by a determination of ineligibility made by the Department or by voluntary withdrawal by the Participant.

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

Durable Medical Equipment is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment. Durable Medical Equipment and supplies are items that are reasonable and necessary in amount, duration, and scope to achieve their purpose. Equipment and supplies must be medically necessary, prescribed, delivered in the most appropriate and cost effective manner, and may not be excluded by state or federal rules or regulations.

EFFECTIVE DATE

The Effective Date of the Participant's coverage means the date the Participant is determined eligible for Benefits by the Department.

EMERGENCY CARE

Health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

EMERGENCY MEDICAL CONDITION

An Emergency Medical Condition is a condition manifesting itself by symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in any of the following:

- The Participant's health would be in serious jeopardy;
- The Participant's bodily functions would be seriously impaired; or
- A bodily organ or part would be seriously damaged.

EVIDENCE OF COVERAGE

This document.

EXCLUSION

Services not paid for with state and federal funds by the HELP Program Coverage Group.

FAMILY

Means one or more children residing in the same household with a parent, adoptive parent, guardian, or caretaker relative. A Family may also be an emancipated Child or a Child living independently. The Department may determine if a household is a "Family" for purposes of HELP Program eligibility.

FREESTANDING INPATIENT FACILITY

For treatment of Chemical Dependency, it means a facility which provides treatment for Substance Abuse in a community-based residential setting for persons requiring 24-hour supervision and which is a Chemical Dependency Treatment Center. Services include medical evaluation and health supervision; Chemical Dependency education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Health, it means a facility licensed by the state and specializing in the treatment of Mental Health.

HOSPITAL

A short-term, acute-care, general Hospital licensed by the state where it is located and which:

- Primarily provides facilities for diagnosis and therapy for medical/surgical treatment under the supervision of a staff of Physicians; and
- Provides 24-hour-a-day nursing services under the supervision of registered graduate nurses.

The term "Hospital" does not include the following, even if such facilities are associated with a Hospital:

- A nursing home;
- A rest home;
- Hospice;
- A rehabilitation facility;
- A skilled nursing facility;
- A convalescent home;
- A place for care and treatment of Substance Use Disorder;
- A place for treatment of Mental Health;
- A long-term, chronic-care institution or facility providing the type of care listed above.

IDENTIFICATION (ID) CARD

A document issued to each Montana Health and Economic Livelihood Partnership Participant that identifies that Participant as eligible for the Montana Health and Economic Livelihood Partnership Coverage Group.

ILLNESS

An alteration in the body or any of its organs or parts, which interrupts or disturbs the performance of vital functions, thereby causing or threatening pain or weakness; a sickness or disease.

INCLUSIVE SERVICES/PROCEDURES

- A portion of a service or procedure which is Medically Necessary for completion of the service or procedure; or
- A service or procedure which is already described or considered to be part of another service or procedure.

INJURY

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

INSTITUTE FOR MENTAL DISEASE (IMD)

An institution for the treatment and care of persons suffering from mental diseases under Medicaid regulations (42 CFR § 440.160).

INPATIENT (OR HOSPITAL INPATIENT)

Services or supplies provided to the Participant who has been admitted to a Hospital as a registered bed patient and who is receiving services under the direction of a Participating Provider with staff privileges at that Hospital.

INPATIENT BENEFITS (FOR SUBSTANCE USE DISORDER OR MENTAL HEALTH)

The payment to a Provider for services for Medically Necessary care and treatment of Substance Use Disorder or Mental Health which are provided in a setting that is medically appropriate. Such services must be provided:

- By a Hospital, Freestanding Inpatient Facility, or Physician; and
- While Participants are in a Hospital Inpatient; or
- While Participants are confined as an Inpatient in a Freestanding Inpatient Facility.

INTERPRETER SERVICES

The HELP Program will pay for Interpreter Services provided to eligible HELP Participants if:

- The service is a Medically Necessary service;
- The service is a HELP Program covered service;
- Reimbursement is to the provider of the service (the Interpreter), not a third party;
- Another payer is not responsible for payment;
- Services were performed in a prompt, efficient fashion; and
- A complete request for payment is received within 365 days of the service provided. This means that the request for payment will include all information necessary to successfully pay the claim.

INVESTIGATIONAL/EXPERIMENTAL/UNPROVEN SERVICE OR CLINICAL TRIAL

Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of the Department not recognized as conforming to accepted medical practice, or;

The procedure, drug, or device:

- Has not received required final approval to market from appropriate government bodies; or
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes as described by BCBSMT Medical Policy; or
- Is not demonstrated to be as beneficial as established alternatives; or
- Has not been demonstrated to improve the net health outcomes; or
- Is one in which the improvement claimed is not demonstrated to be obtainable outside the Investigational or Experimental setting.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL POLICY

The policy of the BCBSMT which is used to determine if health care services including medical procedures, medication, medical equipment, processes and technology meet nationally accepted criteria, such as:

- Services must have final approval from the appropriate governmental regulatory agencies;
- Scientific studies have conclusive evidence of improved net health outcome; and
- Must be in accordance with any established standards of good medical practice.

MEDICALLY NECESSARY (MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Member receives the services, supplies, or medications and a claim is submitted to The Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MENTAL HEALTH TREATMENT CENTER

A facility which provides treatment for Mental Health through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team, including a licensed Physician, psychiatric social worker, and psychologist. The facility must also be:

- Licensed as a Mental Health Treatment Center by the state;
- Funded or eligible for funding under federal or state law; or
- Affiliated with a Hospital with an established system for patient referral.

MENTAL HEALTH

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

- Present distress or a painful symptom;
- A disability or impairment in one or more areas of functioning; or
- A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Health must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Health does not include:

- Developmental disorders;
- Speech disorders;
- Psychoactive Substance Use Disorders;
- Eating disorders;
- Impulse control disorders (except for intermittent explosive disorder and trichotillomania); and
- Severe Mental Health.

MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PROGRAM COVERAGE GROUP

The Coverage Group is a benefit program for eligible Montanans administered by the Department through the Montana Health and Economic Livelihood Partnership Plan.

MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PROGRAM NETWORK

A provider or group of providers who have contracted with Blue Cross and Blue Shield of Montana (BCBSMT) to provide medical and mental health services to Participants covered under the HELP Coverage Group.

MONTH

For the purposes of this Evidence of Coverage, a Month is the actual calendar Month.

MULTIDISCIPLINARY TEAM

When used in the Rehabilitation Therapy portion of the Evidence of Coverage, Multidisciplinary Team is a group of health service providers who must be either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided.

NON-COVERED (OR NON-PARTICIPATING PROVIDER)

Medical and Mental Health (non-covered or non-participating)

Any Provider who is not under contract with the Claim Administrator to provide HELP Coverage Group Benefits. Non-Participating Providers are not included in the HELP Network. Services received from a Non-Participating Provider:

- May not be covered;
- May be covered by the HELP Coverage Group but the provider may refuse payment from the HELP Coverage Group;
- May be subject to Preauthorization; or
- May not be paid by the HELP Coverage Group.

NURSE FIRST

All HELP Participants are eligible to use the 24 hour 7 day nurse advice line called Nurse First. Nurse First is free and can be accessed by calling 1-800-330-7847.

OBSERVATION BEDS/ROOM

Outpatient beds which are used to:

- Provide active short-term medical/surgical nursing services; or
- Monitor the stabilization of the patient's condition.

OCCUPATIONAL THERAPY

Treatment of the physically disabled due to disease, injury, or loss of bodily part by means of constructive activities designed and adapted to promote the restoration of an individual's ability to perform required daily living tasks.

OUT OF POCKET AMOUNT

The combined dollar amount of copayments and premiums are out of pocket costs and are the responsibility of the participant.

OUTPATIENT

Services or supplies provided to Participants by Participating Providers while Participants are not Inpatient.

PARTIAL HOSPITALIZATION FOR MENTAL HEALTH AND SUBSTANCE ABUSE

An ambulatory (Outpatient) program offers active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program offers four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPANT

A Participant who has been certified and notified by the Department as eligible for the HELP Coverage Group. To be eligible to participate, an individual must be:

- A childless adult between 19 and 65 years of age, with an income at or below 138 percent of the Federal Poverty Level (FPL) or a parent between 19 and 65 years of age, with an income between 50-128 percent of the FPL;
- Not enrolled in Medicare;
- A United States citizen or a documented, qualified alien; and a resident of Montana;
- Not currently eligible for Medicaid; and
- Not pregnant when applying.

PARTICIPATING PROVIDER

Medical and Mental Health

A provider in the HELP Program network who will provide medical, dental, and health services

covered in the Evidence of Coverage.

Pharmacy
A provider who is enrolled as a Montana Health Care Programs Provider and who will provide prescription drug services covered under this Evidence of Coverage. (See: https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do)

PHARMACY
Every site properly licensed by the Montana Board of Pharmacy in which practice of Pharmacy is conducted.

PHARMACY (NON-COVERED OR NON-PARTICIPATING)
Any Provider who is not enrolled as a Montana Medicaid Provider. In addition, any provider that is under any sanctions, suspensions, Exclusions or civil monetary penalties imposed by the Medicare program is a Non-Covered Provider. Services received from a Non-Participating or Non-Covered Provider will not be covered.

PHYSICAL THERAPY
The treatment of disease or injury by hydrotherapy, heat or similar modalities, physical agents, biomechanical, and neuro-physiological principles and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or a loss of bodily part.

PHYSICIAN
A person licensed to practice medicine in the state where the service is provided.

PLAN ADMINISTRATOR
State of Montana, Department of Public Health and Human Services.

PREAUTHORIZATION
Approval in advance to obtain services. **Failure to obtain Preauthorization may result in Participants paying out of pocket for the services provided.** Some services are covered only if Participants' doctors or other Participating Providers get "Preauthorization". This process is used to inform HELP Participants whether or not a proposed service, medication, supply, or ongoing treatment is Medically Necessary, based on the Medical Policy, and is a Covered Medical Expense under this Evidence of Coverage.

- For Preauthorization of Medical mental health and Inpatient Federally Qualified Health Center (FQHC) services contact BCBSMT at 1-877-296-8206.
- For Preauthorization of Pharmacy services contact DPHHS's Drug Preauthorization Unit, Mountain Pacific Quality Health at <XXX-XXX-XXXX>.
- For Preauthorization of Dental Services and Eyeglasses contact the HELP Program Dental and Vision Program Officer at <XXX-XXX-XXXX>.
- For Preauthorization of Outpatient Services provided by a Federally Qualified Health Clinic or Rural Health Clinic, and Community Based Psychiatric Rehabilitation Services (CBPRS) contact DPHHS at PH<XXX-XXX-XXXX>.ONE.

PREMIUM
The amount of money which must be paid by the Participant to keep this Evidence of Coverage in force.

PROFESSIONAL CALL
A personal interview between Participants and HELP Participating Providers. HELP Participating Providers must examine Participants and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where Participants are not examined by HELP Participating Providers.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)
Inpatient psychiatric Hospital services.

QUALIFIED INDIVIDUAL (For an Approved Clinical Trial)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life- Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION THERAPY

Specialized treatment, for an injury or physical deficit, which is:

- Provided in an Inpatient or Outpatient setting;
- An intense, comprehensive program of therapies (e.g., Physical Therapy, Occupational Therapy, and Speech Therapy) provided by a Multidisciplinary Team, and also includes associated general and medical services incidental to rehabilitation care;
- Designed to restore the patient's maximum function and independence; and
- Under the direction of a qualified Physician and includes a formal written treatment plan with specific goals.

REHABILITATION UNIT

- Inpatient licensed general Hospital which provides services by a Multidisciplinary Team under the direction of a qualified Physician; or
- Physician's office.

RETROSPECTIVE REVIEW

The Claim Administrator's review of services, supplies, or treatment after they have been provided, and the claim has been submitted, to determine whether or not the services, supplies, or treatment were Medically Necessary.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SEVERE MENTAL HEALTH

The following disorders as defined by the American Psychiatric Association:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder;
- Major depression;
- Panic disorder;

- Obsessive-compulsive disorder; and
- Autism

SPEECH THERAPY

Treatment for the correction of a speech impairment resulting from disease or trauma.

SUBSTANCE ABUSE

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner or other appropriate medical practitioner. Refer to Substance Use Disorder.

SUBSTANCE ABUSE OR SUBSTANCE USE DISORDER TREATMENT CENTER

A facility that provides treatment for Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Physician or a licensed addiction counselor. The facility must be state approved as a Substance Use Disorder Treatment Center by the Department or an equivalent facility licensed by the state where the facility is located.

SUBSTANCE USE DISORDER

Alcoholism, drug addiction, or substance abuse. Inpatient and Outpatient services are available for treatment of Substance Use Disorder.

TELEMEDICINE

The use of a secure interactive audio and video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission.

TREATMENT FACILITY

1. For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorders in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center that is approved by the Montana Department of Public Health and Human Services under Montana Code Annotated (MCA) § 53-24-208 and found at http://leg.mt.gov/bills/mca_toc/. Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group, and Family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up Program after discharge.

2. For treatment of Mental Health, it means a facility licensed by the state specializing in the treatment of Mental Health for persons requiring 24-hour supervision which is:
   a. A Psychiatric Residential Treatment Facility (PRTF).
   b. A therapeutic group home.

URGENT CARE

Medically Necessary care for a condition that is not life threatening but that requires treatment that cannot wait for a regularly scheduled clinical appointment because of the potential of the condition worsening without timely medical intervention.

ARTICLE TWO – PARTICIPATING PROVIDER

This Evidence of Coverage allows benefits for Covered Medical Expenses which are provided by a Participating Provider. A Participating Provider is a provider which has satisfied the necessary qualifications to practice medical care within the state of Montana or another state and which has been recognized by BCBSMT as a Montana Health and Economic Livelihood Partnership (HELP) Program Provider for medical or mental health services or is enrolled as a Montana Health Care Programs Provider for Pharmacy services for benefits described in this Evidence of Coverage. Some providers may be "participating" only for certain specific services because of a limited scope of practice. To determine if a provider is "participating," the HELP Coverage Group looks to the nature of the services rendered, the extent of licensure, and the HELP Coverage Group's recognition of the provider.

HELP Participants may obtain a list of Montana Health and Economic Livelihood Partnership (HELP)

Providers for medical and mental health services from BCBSMT upon request or download it from the BCBSMT website at www.BCBSMT.com.

HELP Participants may obtain a list of enrolled Montana Healthcare Providers for Pharmacy services through a search on the Montana Healthcare Provider website at << DPHHS please provide HELP Pharmacy website link >>

ARTICLE THREE – MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP NETWORK

HELP Program Participants are encouraged to choose a primary care provider from the list of HELP Program Providers. A primary care provider will be better able to know Participants and their medical history, determine Participants' health care needs, and help Participants use the Medically Necessary Benefits available under the HELP Program Coverage Group.

Section I: Use of the Montana Health and Economic Livelihood Partnership Network

HELP Program Participants are encouraged to have their care directed by the primary care providers they select. Generally, Participants need to make an appointment with their HELP Program Providers. Participants' primary care providers will provide health care, or if Participants' primary care providers determine it is Medically Necessary to do so, may refer Participants to another care provider or recommend a specialist in the HELP Program Network. They will also help Participants arrange or coordinate Medically Necessary hospitalization. Benefits for certain Medically Necessary services, including obstetrical and gynecological services, are available without a recommendation from Participants' primary care providers when Participants use the HELP Program Network.

If HELP Program Participants have not chosen a primary care provider, they still need to use the HELP Program Program Network to obtain Benefits.

Covered medical and mental health Benefits are only available if Participants use the HELP Program Network, except:

1. If the Medically Necessary services are not available in the HELP Program Network; AND
2. Preauthorization has been approved by BCBSMT on behalf of the HELP Program.

Covered Pharmacy services must be obtained through an enrolled Montana Health Care Programs Provider.

In the situations listed above, Participants must receive Preauthorization from the Claim Administrator. If Participants do not obtain Preauthorization, then such services are not a Benefit of this EOC and Participants will be responsible for payment of the costs of the services provided.

Section II: Private Pay Agreement or Advance Benefit Notification (ABN)

The Claim Administrator will review claims to determine if the services were Medically Necessary. The HELP Program Coverage Group does not pay for services that are determined to not be Medically Necessary.

When a service is denied as non-covered, Participating Providers may not balance bill the Participant for the services, unless the Participant or the Participant's authorized representative has signed an ABN. For services non-covered, providers may bill Participants only when providers and Participants have agreed in writing prior to the services being provided.

Section III: Emergency Care and Urgent Care

Emergency Care
If Participants need Emergency Care, go to the nearest doctor or Hospital. Participants may need Emergency Care if their condition is severe, if they have severe pain, or if they need immediate medical attention to prevent any of the following:

- Serious jeopardy of the Participant's health
- Serious damage to the Participant's bodily functions

- Serious damage to a bodily organ or part

Participants should notify their primary care provider as soon as possible that they have received Emergency Care and plan to receive follow-up care from their primary care provider.

Urgent Care
Some situations require prompt medical attention although they are not emergencies. In these situations, it is recommended that Participants call their primary care provider and describe the situation. He or she will then direct Participants' care.

Unless Participants get approval from the Claim Administrator, they must receive Urgent Care from a HELP Provider. If Participants receive services from a provider who is not a HELP Providers, they may have to pay for these services.

Before receiving Emergency Care or Urgent Care, Participants can call Nurse First, the 24 hour 7 day nurse advice line. Nurse First is free and can be accessed by calling 1-800-330-7847.

Section IV: Out-of-State Services

HELP Program Participants cannot get routine or non-emergency or non-urgent care without the HELP Program Coverage Group's approval when Participants are out of state. Participants who spend time away from home will have care paid for if the HELP Program Coverage Group approves the service. The HELP Program Coverage Group must give Preauthorization approval in these instances.

Medically Necessary Services for a Participant receiving care from a HELP Program provider outside of Montana, but in a county bordering Montana, are covered.

Out-of-state Pharmacy benefits may only be paid if the provider is enrolled as a Montana Health Care Programs Provider.

Section V: Prohibition on Payment Outside of the United States

No payment for items or services of medical assistance can be made to any provider located outside of the United States.

ARTICLE FOUR – PREAUTHORIZATION

BCBSMT has designated certain covered services which require Preauthorization in order for the Participant to receive the maximum Benefits possible.

The Participant is responsible for satisfying the requirements for Preauthorization. This means that the Participant must request Preauthorization or assure that the Participant's Physician, provider of services, the Participant's authorized representative, or a family member complies with the requirements below. If the Participant utilizes a Network Provider for covered services, that provider may request Preauthorization for the services. However, it is the Participant's responsibility to assure that the services are preauthorized before receiving care.

To request Preauthorization, the Participant or his/her Physician must call the Preauthorization number shown on the Participant's Identification Card **before** receiving treatment. BCBSMT will assist in coordination of the Participant's care so that his/her treatment is received in the most appropriate setting for his/her condition.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits.

***Section I:* Preauthorization Process for Inpatient Services**

For an Inpatient facility stay, the Participant must request Preauthorization **before** the Participant's scheduled admission. BCBSMT will consult with the Participant's Physician, Hospital, or other facility to determine if Inpatient level of care is required for the Participant's Illness or Injury. BCBSMT may decide that the treatment the Participant needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office).

If BCBSMT determines that the Participant's treatment does not require Inpatient level of care, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay without approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, BCBSMT will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the EOC, the Participant will be responsible for the full cost of the services.

Section II: **Preauthorization Process for Mental Health, Severe Mental Health and Substance Abuse Services**

All Inpatient and partial hospitalization services related to treatment of Mental Health, Severe Mental Illness and Substance Abuse must be Preauthorized by BCBSMT. Preauthorization is also required for the following Outpatient Services:

- Psychological testing;
- Neuropsychological testing;
- Electroconvulsive therapy;
- Intensive Outpatient Treatment; and
- Repetitive Transcranial Magnetic Stimulation.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform covered services. However, all services are subject to the provisions in the section entitled Concurrent Review.

If BCBSMT determines that the Participant's treatment does not require Inpatient or partial hospital level of care, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay or partial hospital level of care, without approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, BCBSMT will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of this EOC, the Participant will be responsible for the full cost of the services.

Section III: **Preauthorization Process for Other Outpatient Services**

In addition to the Preauthorization requirements outlined above, BCBSMT also requires Preauthorization for certain Outpatient services, including Home Health Care and Hospice Services. For additional information on Preauthorization, the Participant or the Provider may call the Customer Service number on the Participant's identification card.

It is NOT necessary to preauthorize standard x-ray and lab services or Routine office visits.

If BCBSMT does not approve the Outpatient Service, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with the services without approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, BCBSMT will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of this EOC, the Member may be responsible for the full cost of the services.

The Benefits section of this EOC details the services which are subject to Preauthorization.

Section IV: **Preauthorization Request Involving Emergency Care**

If the Participant is admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, the Participant's Provider must notify BCBSMT within two working days following the

Participant's emergency admission.

Section V: **Preauthorization Required For Certain Prescription Drug Products and Other Medications**

Prescription Drug Products, which are self-administered, process under the Prescription Drug Program Benefit of this EOC. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

1. **Prescription Drugs – Covered Under the Prescription Drug Program Benefit**

   Certain prescription drugs, which are self-administered, require Preauthorization. Please refer to the Prescription Drug Program section for complete information about the Prescription Drug Products that are subject to Preauthorization and quantity limits, the process for requesting Preauthorization and related information.

2. **Other Medications – Covered Under Medical Benefits**

   Medications that are administered by a Covered Provider will process under the medical Benefits of this EOC. Certain medications administered by a Covered Provider require Preauthorization. The medications that require Preauthorization are subject to change by BCBSMT.

   To determine which medications are subject to Preauthorization, please refer to the Prescription Drug Program section for complete information.

Section VI: **General Provisions Applicable to All Required Preauthorizations**

1. **No Guarantee of Payment**

   Preauthorization does not guarantee payment of Benefits. Even if the Benefit has been Preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date of service or the Participant's may have changed as of the date the service.

2. **Request for Additional Information**

   The Preauthorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Preauthorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSMT to make a determination of coverage pursuant to the terms and conditions of this EOC.

3. **Failure to Obtain Preauthorization**

   If the Participant does not obtain Preauthorization, BCBSMT will conduct a retrospective review after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary, performed in the appropriate setting, and otherwise meet the terms and conditions of this EOC. The Participant may be responsible for charges for any Benefits which were not performed in the appropriate setting, were not Medically Necessary, were Experimental, Investigational or Unproven, or did not otherwise meet the terms and conditions of this EOC, including any applicable Medical Policy.

Any treatment the Participant receives which is not a covered service under this Evidence of Coverage, or is not determined to be Medically Necessary, or is not performed in the appropriate setting will be excluded from the Participant's Benefits. This applies even if Preauthorization approval was requested or received.

Section VIII: **Concurrent Review**

Whenever it is determined by BCBSMT, that Inpatient care or an ongoing course of treatment may no longer meet medical necessity criteria or is considered Experimental/Investigational/Unproven, the Participant, Participant's Provider or the Participant's authorized representative may submit a request

to BCBSMT for continued services.

Section IX: Wellness Program

Montana Health and Economic Livelihood Partnership (HELP) Program includes a comprehensive Health and Wellness Program for Participants in the HELP Program with a focus on engaging Participants, their families, and providers. The components of this program have been designed to:

- Improve Participants' knowledge of lifestyles that are healthy and promote wellness;
- Improve Participants' understanding of chronic health conditions;
- Provide easy access to validated, accurate health information; and
- Inform Participants of health and self-care and how to access plan benefits.

BCBSMT's health education program for health and wellness promotion for the HELP Program is a comprehensive program comprised of three separate components including:

- An annual Participant communication,
- Condition (disease) management, and
- Physician education.

Section X: On-Line Education Tools

Montana Health and Economic Livelihood Partnership (HELP) Program Participants have access to on-line tools and mailed materials upon request. The following topics are available:

- The availability and benefits of preventive health care;
- Targeted disease management education;
- Healthy pregnancy;
- Appropriate ER utilization;
- Injury prevention;
- The importance of and schedules for screenings for cancer, high blood pressure and diabetes;
- The risks associated with the use of alcohol, tobacco and other substances;
- Healthy lifestyle choices such as exercise, balanced diet, maintaining an appropriate weight, stress reduction, and the importance of sleep;
- The concepts of managed care;
- The use of the PCP or a PCMH as the primary source of medical care; and
- Ask Me3 – educational information regarding how to ask your doctor questions during a medical appointment.

Annually Participant's receive materials containing:

- Primary prevention and health education;
- BCBSMT Participant newsletters with a variety of articles of general health interest and primary prevention for this population;
- Reminder post-cards about immunizations and preventative services; and
- Exercise and physical activity pamphlet

Web-based education:

Web-based education is offered through Well onTarget^{SM}, a dynamic new condition management tool that Participants can use to learn about and manage their condition. It also provides an opportunity to increase engagement by giving Participants alternative means to enroll in care management programs. Well onTarget complements the robust catalog of health and wellness tools already available to all Participants. Participants have access to the following:

- **Health Risk Assessments (HRA):** Online HRAs allow Participants to answer basic questions about their health with their answers stored in one, secure place. They can take CAs for asthma, coronary artery disease, diabetes, depression and substance abuse.

- **Online Health Tutorials:** Based on answers to the HRA, Well onTarget will suggest online tutorials to help Participants better understand their care needs and offer ways for them to take a more active role in their care.
- **Health Resources:** This section allows Participants to obtain useful health information from well-known and recognized groups such as the National Institutes of Health (NIH) and Centers for Disease Control and Prevention.

Participants can log on to Well onTarget by choosing the link in the My Health tab in their Blue Access for Participants℠ (BAM) account. BAM is the web-based Participant portal available to BCBSMT Participants.

Section XII: Condition Management

Condition Management provided by BCBSMT clinical staff is the most important one-on-one vehicle for health education. Identified Participants are stratified by his/her risk into one of three levels depending upon his/her use of services, co-morbidities and/or gaps in care. All Participants with "care gaps" are flagged in the care management system and used in the Participant risk stratification. The stratification is continuously updated based on data analysis of cost and prevalence, referral from BCBSMT medical management staff, contracted providers, registry development, stratification by severity criteria, interventions by stratification and outcomes measurement.

BCBSMT provides the following condition and lifestyle management programs:

- Diabetes
- Asthma
- Hypertension
- Special Beginnings Maternity Management
- Weight Management
- Smoking cessation

Interventions are designed to afford Participants the opportunity to acquire self-care information that will enhance the Participant's knowledge about risk factors and to improve the Participant's ability to work with his/her physician to identify treatment regimens appropriate to prevent complications and to improve the Participant's quality of life.

Special Beginnings Maternity Management

The Special Beginnings® Program is a comprehensive maternity program designed to help expectant Participants better understand and manage their pregnancy. The program focuses on providing Participants with educational resources and additional support throughout their pregnancy and postpartum care.

Participants can access a new online resource tool for expectant mothers located on Blue Access® for Participants. The online tool provides the following resources:

- Pregnancy calendar to help keep track of the pregnancy and what to expect in each trimester
- A pregnancy due date calculator
- Videos about pregnancy and childbirth with professionals such as clinical psychologists and registered nurses
- Educational articles

Upon enrollment into Special Beginnings, Participants are screened for risk stratification, low, moderate or high. Low risk Participants receive outreach every trimester and at 2 weeks post-partum but are followed through 6 weeks post-partum. They are continually screened for a change in risk stratification during their pregnancy.

Participants receive an informational packet which includes:

- Prenatal care book
- Infant care information
- Back to Sleep – safe sleep information

- Breastfeeding information

Participants screened as moderate are managed by a Maternal/Child Health nurse and receive monthly outreach. Participants identified as High Risk OB are referred to a Complex Case Manager who specializes in Maternal/Child Health.

ARTICLE FIVE – COVERED BENEFITS

NOTE: Other sections of this EOC may limit the availability of the Benefits listed in this Article.

The HELP Program Coverage Group will make payment for certain professional Provider and Hospital services based on the Allowable Fee for Covered Medical Expenses provided by Participating Providers during the Benefit Period and while this EOC in force. (Please read Article Two entitled "Participating Provider.")

Section I: Inpatient Hospital Services

BCBSMT administers claims for Inpatient Hospital Services and Preuthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

1. Room and Board Accommodations include:

    a. Room and board, which includes special diets and nursing services; and
    b. Intensive care and cardiac care units only when such service is Medically Necessary. Intensive care and cardiac care units include:
        1) Special equipment; and
        2) Concentrated nursing services provided by nurses who are Hospital employees.

2. Miscellaneous Inpatient Hospital Benefits include:

    a. Laboratory procedures;
    b. Operating room, delivery room, recovery room;
    c. Anesthetic supplies;
    d. Surgical supplies;
    e. Oxygen and use of equipment for its administration;
    f. X-ray;
    g. Intravenous injections and setups for intravenous solutions;
    h. Special diets when Medically Necessary;
    i. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy;
    j. Physical Therapy, Speech Therapy, and Occupational Therapy; and
    k. Drugs and medicines which:
        1) Are approved for use in humans by the U.S. Food and Drug Administration.
        2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons.
        3) Require a Physician's written order.

3. Transplant Benefits include:

    a. Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants.
    b. For organ and tissue transplants involving a living donor, transplant organ/tissue procurement and transplant-related medical care for the living donor are covered.
    c. Transplants of a nonhuman organ or artificial organ implant are not covered.
    d. Donor searches are not covered.

    For certain transplants, BCBSMT contracts with a number of Centers of Excellence that provide transplant services. BCBSMT highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Participants being considered for a transplant procedure are encouraged to contact BCBSMT Customer Service to discuss the possible benefits of utilizing the Centers of Excellence.

4. Nursery Care Benefits include:

    a. Hospital nursery care of a newborn infant of an HELP Program Participant is a covered service during the infant's eligibility period.
    b. The initial care of a newborn at birth provided by a Physician.
    c. Nursery care for newborns born into an HELP Program Family may be covered if the Department is notified in the Month of the birth or within ten (10) days following the birth if the baby is born at the end of the Month. (Please see Article Five, Section XIV: Newborn Care – Care of newborn of non-covered Family Participant for important notification requirements.)

Section II: Observation and Recovery Beds/Rooms

BCBSMT administers claims for Observation/Recovery Beds/Rooms and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

Payment will be made for Observation Beds/Rooms and Recovery Care Beds/Rooms when necessary, and in accordance with BCBSMT Medical Policy guidelines. Observation and Recovery Beds/Rooms services are subject to the following limitations:

1. The HELP Program Coverage Group will pay Observation Beds/Room and Recovery Care Bed Benefits when provided for less than 24 hours.
2. Benefits for Observation Beds/Rooms and Recovery Care Beds/Rooms will not exceed the semiprivate room rate that would be billed for an Inpatient stay.

Section III: Outpatient Hospital Services

BCBSMT administers claims for Outpatient Hospital Services. Participating Providers may contact BCBSMT at 1-877-296-8206.

Outpatient services include:

1. Emergency room care for accidental injury;
2. Emergency room care for an Emergency Medical Condition;
3. Use of the Hospital's facilities and equipment for surgery; and
4. Use of the Hospital's facilities and equipment for respiratory therapy, chemotherapy, radiation therapy, and dialysis therapy.

Section IV: Outpatient Therapies – Please refer to Section XI: Rehabilitation Therapy Benefits

Section V: Outpatient Diagnostic Services

Outpatient Diagnostic Services provided by Federally Qualified Health Centers and Rural Health Clinic claims are administered by DPHHS at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/

The following Outpatient Diagnostic Services include:

1. Diagnostic x-ray examinations;
2. Laboratory and tissue diagnostic examinations; and
3. Medical diagnostic procedures (machine tests such as EKG, EEG).

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Section VI: Freestanding Surgical Facilities (Surgicenters)

Freestanding Surgical Facility claims are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-877-296-8206. Preauthorization is required.

The following surgicenter services are available if:

1. The center is licensed by the state in which it is located or certified for Medicare;
2. The center has an effective peer review program to assure quality and appropriate patient care; and
3. The surgical procedure performed is:
   a. Recognized as a procedure which can be safely and effectively performed in an Outpatient setting; and
   b. One which cannot be appropriately performed in a doctor's office.

Section VII: Mammograms

Claims for mammograms are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-877-296-8206.

Section VIII: Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's current recommendations; and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

   In addition to the screening services recommended under the HRSA Guidelines, the following services are included:

   a. Lactation Services

      Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, BCBSMT will reimburse the Participant the actual cost for the purchase of a breast pump once per birth event. Hospital-grade pumps can be rented, per Medical Policy criteria. For additional information, access www.bcbsmt.com and click on "New Mothers."

   b. Contraceptives

      Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity. For additional information, access www.bcbsmt.com and click on the Members tab and select Pharmacy; and

4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.

Examples of Preventive Health Care services include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations.

For more detailed information on all covered services, contact Customer Service at 1-800-XXX-XXXX or access www.bcbsmt.com.

Section IX: Post-mastectomy Care

Post-mastectomy Care claims are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer. Covered services include, but are not limited to:

1. Inpatient care for the period of time as determined by the attending Physician, in consultation with the Participant, to be necessary following a mastectomy, a lumpectomy, or a lymph node dissection for

the treatment of breast cancer. Preauthorization is required for Inpatient Hospital services.
2. All stages of reconstructive breast surgery after a mastectomy are covered.
3. The cost of the breast prosthesis as the result of the mastectomy is covered.
4. All stages of one reconstructive breast surgery on the non-diseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.
5. Chemotherapy.
6. Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Section X: Surgical Services

Surgical Services Billed by a Professional Provider
Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Surgical Services Billed by an Outpatient Surgical Facility or Freestanding Surgery Centers

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to assure quality and appropriate patient care. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

BCBSMT will pay for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an inpatient stay.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)
Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or Inpatient setting, including the usual care before and after surgery.

Section XI: Anesthesia Services

BCBSMT administers anesthesia services. Participating Providers may contact BCBSMT at 1-877-296-8206.

Anesthesia services provided by a Physician (other than the attending Physician or assistant), or nurse anesthetist are generally Covered Medical Expense if the services are determined to be Medically Necessary to provide care for a condition covered by this Evidence of Coverage.

Anesthesia services include:

1. Administration of spinal anesthesia;
2. The injection or inhalation of a drug or other anesthetic agent used to cause muscles to relax, or a loss of sensation or consciousness; and
3. Supervision of the individual administering anesthesia.

The Allowable Fee for the anesthesia performed during the surgery includes the pre-surgery anesthesia consultation.

Exclusions to Anesthesia Benefit coverage under the HELP Program Coverage Group are:

1. Hypnosis;
2. Local anesthesia that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures; and
4. Anesthesia for Dental services or extraction of teeth, except as included in the Dental Treatment section of this EOC.

Section XII: Rehabilitation Therapy Benefits

Outpatient Rehabilitation Therapy Covered Medical Expense claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

All other Outpatient Rehabilitation Therapy Covered Medical Expense are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

Outpatient Rehabilitation Therapy Benefits are described below:

1. Therapy service provided to Participants by a Multidisciplinary Team under the direction of a qualified Physician.
2. Members of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed Speech Therapist, licensed Physical Therapist, or licensed Occupational Therapist.
3. Services must be Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.
4. Outpatient rehabilitation therapy does require Preauthorization.

Inpatient Rehabilitation Therapy Covered Medical Expense are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

Inpatient Rehabilitation Therapy Benefits are described below:

1. Therapy service provided to Participants by a Multidisciplinary Team under the direction of a qualified Physician.
2. Participants of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed speech therapist, licensed physical therapist, or licensed occupational therapist.
3. Services must be Medically Necessary to improve or restore bodily function and the Participant must continue to show reasonable progress.

Rehabilitation Therapy Benefit Exclusions:

1. Rehabilitation Therapy is not covered when the primary reason for the therapy is one of the following:
   a. Custodial care;
   b. Diagnostic admissions;
   c. Maintenance, nonmedical self-help, or vocational educational therapy;
   d. Learning and developmental disabilities;
   e. Social or cultural rehabilitation; and
   f. Visual, speech, or auditory disorders.

Section XIII: Medical Services (Non-Surgical)

Medical services are those non-surgical covered services provided by Participating Providers during office, home, or Hospital visits which do not include surgical or maternity services. Outpatient medical service claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov.

Outpatient Medical services (non-surgical) include the following:

1. Outpatient medical services include physical examinations and immunizations provided for home, office and Outpatient Hospital Professional Calls.
2. Services provided via telemedicine are allowed.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Inpatient claims for services provided by FQHCs and all other inpatient claims are processed through BCBSMT. Preauthorization may be required for certain non-surgical medical services administered by

BCBSMT. It is recommended Participating Providers contact BCBSMT at 1-877-296-8206 if they are uncertain whether a Covered Medical Expense needs Preauthorization.

Inpatient Medical services (non-surgical) include the following:

1. Inpatient medical services are covered for eligible Hospital admissions.
2. Medical care visits, limited to one visit per day per Participating Provider.
3. Intensive medical care rendered to Participants whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.
4. Concurrent Care services.
5. Consultation Services are services of a consulting Physician requested by the attending Physician. These services include:
   a. Evaluation and management service provided at the request of another Participating Provider;
   b. The consultant's opinion and any services ordered or performed must be documented in the Participant's medical record and communicated by written report to the requesting Participating Provider; and
   c. Evaluation and management consultation services requested by a Participating Provider from a non-Participating Provider and subsequent referrals or treatment services must be Prior Authorized by BCBSMT.

   Benefit coverage will not be provided under the HELP Coverage Group for:
   a. Staff consultations required by Hospital rules, and
   b. Family consultations.

Section XIV: Maternity Services

BCBSMT administers claims for maternity services and Preauthorization is required for Hospital admissions. For Preauthorization contact BCBSMT at 1-877-296-8206.

Payment for any maternity services is limited to the Allowable Fee for total maternity care which includes:

1. Prenatal and postpartum care delivery of one or more newborns.
2. In Hospital medical services for conditions related directly to pregnancy.
3. Prenatal vitamins.

Inpatient Hospital care following delivery will be covered for the length of time determined to be Medically Necessary. At a minimum, Inpatient care coverage will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of Inpatient stay to less than that stated above must be made by the attending Participating health care provider and the mother.

Section XV: Newborn Care

- Newborn care claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at <XXX-XXX-XXXX>. Applicable guidance for claims submission for services provided by these types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/

- BCBSMT administers newborn care claims for all other types of providers. Participating Providers may contact BCBSMT at 1-877-296-8206.

Newborn of **Covered Participant**:

Benefits are provided for the newborn baby of eligible Participants. Covered Medical Expenses must be provided by Participating Providers and can include:

1. The initial care of a newborn at birth provided by Participating Providers,
2. Covered Medical Expenses for <X> days following the birth.
   a. The newborn services will be provided under the eligible Participant's coverage.

b. Coverage for the newborn will terminate at the end of the <X> -day period.
c. In order to avoid interruption in coverage for the newborn, an HELP application for eligibility for the newborn must be received prior to the end of the <X> -day period.

Continued HELP Program coverage after birth for the newborn is subject to meeting eligibility requirements as determined by the Department.

Section XVI: Early Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

EPSDT services are provided by BCBSMT. EPSDT services are comprehensive and preventive health care services for children up to the age of 21. These services do not require copayment. EPSDT services include:

- Comprehensive health and developmental history, physical exam, immunizations, lab tests and health education
- Vision services including diagnosis and treatment, including eyeglasses
- Dental services
- Hearing services

Section XVII: Vision Benefits and Medical Eye Care

- Vision claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at <XXX-XXX-XXXX>. Applicable guidance for claims submission for services provided by these types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.hhs.mt.gov/providerpages/providertype/providertype.shtml.
- BCBSMT administers vision claims for all other types of providers. Participating Providers may contact BCBSMT at 1-877-296-8206.

Vision Benefits include:

1. Services for the medical treatment of diseases or injury to the eye by a licensed Physician or optometrist working within the scope of his/her license.
2. Vision exams.
3. Claims for eyeglasses are administered by DPHHS. Providers may contact DPHHS at 1-800-624-3958.
   a. Eyeglasses are available through the Department by the Medicaid Dental and Vision Program Officer.
   b. Glasses are limited to one pair annually.
   c. Contact lenses are not covered.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Section XVIII: Dental Services

Dental claims (non-medical) are administered by DPHHS. Participating Providers may contact DPHHS at 1-800-624-3958.

Dental Benefits include:

1) Dental treatment services with annual cap are limited to $1,125 each July to June;
2) Dental preventive services; and
3) Dental dentures services.

Additional information can be found on the DPHHS' website at: http://medicaidprovider.mt.gov/.

The HELP Program Coverage Group may pay for Medically Necessary services provided by dentists and oral surgeons for the initial repair or replacement of sound natural teeth damaged as a result of an Accident. Dental Accidents should be reported immediately to the Dental Program Officer at <XXX-XXX-XXXX> or BCBSMT at 1-877-233-7055.

Inpatient Dental Services include:

1. Services and supplies provided by a Hospital in conjunction with Dental treatment will be covered only when a non-dental physical Illness or injury exists which makes Hospital care Medically Necessary to safeguard the Participant's health. Things such as complexity of Dental treatment and length of anesthesia are not considered non-dental physical Illness or injury.
2. Other conditions are subject to medical review and Preauthorization.

Exclusions to Outpatient and Inpatient Dental Services include:

1. Orthodontics,
2. Dentofacial orthopedics, or
3. Related appliances.

Section XIX: Dental Fluoride

Dental varnish fluoride applications are covered when provided by a Physician or dentist. Prescribed oral fluoride preparations are a covered Pharmacy benefit.

Claims for Dental fluoride provided by a Dentist are administered by DPHHS. Participating Providers may contact DPHHS at 1-800-624-3958.

Blue Cross and Blue Shield of Montanan administers claims for Dental fluoride provided by Physicians. Participating Providers may contact BCBSMT at <<1-855-313-8914>>.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XX: Audiological Services
Audiology services are hearing aid evaluations and basic audio assessments provided to Participants with hearing disorders within the scope of service permitted by state law.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/

Section XXI: Hearing Aid Services
For a hearing aid to be covered, the Participant must be referred by a Physician or mid-level practitioner for an audiological exam, and the Physician or mid-level practitioner must have determined that a hearing evaluation would be medically appropriate to evaluate the patient's hearing loss.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XXII: Radiation Therapy Service

BCBSMT administers claims for radiation therapy Covered Medical Expenses. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician for the treatment of disease is covered.

Section XXIII: Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration ordered by the attending Physician for the treatment of disease is covered.

Section XXIV: Diabetic Education

BCBSMT administers diabetic education claims for Covered Medical Expenses. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

The HELP Program Coverage Group covers Outpatient diabetic education services. Covered services include programs for self-management training and education as prescribed by a licensed health care professional with expertise in diabetes.

Please see Section XXXIV: Durable Medical Equipment (DME) and Medical Supplies for important information regarding diabetic equipment and supplies covered by the HELP Program Coverage Group.

Section XXV: Montana Diabetes Prevention Program

The program offers an intensive, ten month, lifestyle management intervention focusing on; behavior change, healthy eating strategies and ways to become more active. The program is facilitated by trained lifestyle coaches that encourage, coach and motivate participants to adopt sustainable lifestyle changes.

Additional information can be found on the Department's website at:
http://dphhs.mt.gov/publichealth/Diabetes/DPP.aspx.

Section XXVI: Diagnostic Services – Please refer to Section V: Outpatient Diagnostic Services

Section XXVII: Mental Health Inpatient and Outpatient Benefits

Benefits for Mental Health will be paid as any other Illness.

Outpatient Services

Care and treatment for Mental Health when the Participant is not an Inpatient Participant and provided by:

1. a Hospital;
2. a Physician or prescribed by a Physician;
3. a Mental Health Treatment Center;
4. a Substance Abuse Treatment Center;
5. a psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. an addiction counselor licensed by the state; or
9. a licensed psychiatrist.

Outpatient services are subject to the following conditions:

1. the services must be provided to diagnose and treat recognized Mental Health; and
2. the treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Mental Health.

Inpatient Care Services

Care and treatment of Mental Health, while the Participant is an Inpatient Participant, and which are provided in or by:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits.

Preauthorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Preauthorization.

Partial Hospitalization

Care and treatment of Mental Health, while the Partial Hospitalization services are provided by:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Preauthorization is required for Partial Hospitalization services. Please refer to the section entitled Preauthorization.

Mental Health Outpatient Benefits

- Mental health Outpatient claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at <XXX-XXX-XXXX>. Applicable guidance for claims submission for services provided by these types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/

- BCBSMT administers Mental Health Outpatient benefit claims for all other types of Participating Providers. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

1. The HELP Coverage Group will pay for Outpatient mental health services that are Covered Medical Expenses if provided by a Participating Provider. Outpatient mental health services may be furnished in a variety of settings:
   a. Community based settings; or in a
   b. Mental health Hospital.

2. Mental Health Outpatient Benefits include individual, family and/or group psychotherapy office visits.
3. Services provided via telemedicine are allowed.

Section XXVIII: Severe Mental Health

The HELP Program Coverage Group will pay the Allowable Fee for Medically Necessary services provided by a licensed Physician, licensed advanced practice registered nurse with prescriptive authority and specializing in mental health, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician.

Section XXIX: Substance Use Disorder

Payment by the DPHHS for Substance Use Disorder services of Participating Providers will be based on the Allowable Fee and is subject to the copayments. These services must be Medically Necessary and provided by a Participating Provider. (Please read Article Three entitled “Participating Providers.”)

BCBSMT administers claims for Substance Use Disorder Inpatient and Outpatient services and Preauthorization is required for Inpatient services. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>. Preauthorization is required for Inpatient benefits.

Benefits for Substance Abuse will be paid as any other Illness.

Outpatient Services

Care and treatment for Substance Abuse when the Participant is not an Inpatient Participant and provided by:

1. a Hospital;
2. a Mental Health Treatment Center;
3. a Substance Abuse Treatment Center;
4. a Physician or prescribed by a Physician;
5. a psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. an addiction counselor licensed by the state; or
9. a licensed psychiatrist.

Outpatient services are subject to the following conditions:

1. the services must be provided to diagnose and treat recognized Substance Abuse;
2. the treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Abuse; and
3. no Benefits will be provided for hypnotherapy or for services given by a staff Participant of a school or halfway house.

Inpatient Care Services

Care and treatment of Substance Abuse, while the Participant is an Inpatient Participant, and which are provided in or by:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits.

Preauthorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Preauthorization.

Partial Hospitalization

Care and treatment of Substance Abuse, while the Partial Hospitalization services are provided by:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Preauthorization is required for Partial Hospitalization services. Please refer to the section entitled Preauthorization.

Section XXX: Transportation Ambulance Services

DPHHS administers claims for Ambulance services. Providers may contact DPHHS at 1-800-624-3958.

Licensed ground and air Ambulance services are covered to the nearest Hospital equipped to provide the necessary treatment, when the service is for a life-endangering medical condition or injury. Ambulance transport must be Medically Necessary meaning other forms of transportation would endanger the health of the Participant.

Additional information can found on the Department's website at: http://medicaid provider.mt.gov/.

Section XXXI: Specialized Non-Emergency Transportation

Specialized non-emergency transportation is for participants who are wheelchair bound or must be transported by stretcher.

Additional information can found on the Department's website at: http://medicaid provider.mt.gov/.

Section XXXII: Personal and Commercial Transportation

Commercial transportation is for participants who do not have special transportation requirements. Commercial transportation services are provided by air or ground commercial carrier, taxicab, or bus for a participant to receive medical care. Commercial transportation is covered only when it is the least costly form of transportation. Participants must obtain Preauthorization from the Transportation Center for this service. The participant or his/her designee must call in or fax all non-emergent transportation requests to the Transportation Center before the services are provided.

The Transportation Center completes the following procedures for each transportation request:
• Verifies current eligibility
• Confirms Team Care provider approval, if necessary
• Confirms individual appointments
• Confirms that the service is covered
• Determines the least expensive and most appropriate mode of travel
• Determines the closest site of service

Medicaid Transportation Center
MPQH
P.O. Box 6488
Helena, MT 59604-6488
Phone
800-292-7114 In/Out of state
406-443-6100 Helena
Fax
800-291-7791 In/Out of state

Section XXXIII: Transportation and Per Diem

DPHHS administers claims for transportation and per diem covered Benefits. Providers may contact Xerox at 1-800-624-3958.

The HELP Program Coverage Group will provide financial assistance towards expenses for HELP Participants' transport, meals and lodging while enroute to Medically Necessary medical care. It is important to have Participants' Participating Providers submit requests for Preauthorization to the Claim Administrator and receive approval for Medically Necessary medical care before submitting Preauthorization for travel and per diem.

Additional information can be found on the Department's website at: http://medicaid provider.mt.gov/.

Section XXXIV: Prescription Drugs

Drug coverage is limited to those products where the pharmaceutical manufacturer has signed a rebate agreement with the Federal government. Federal regulations further allow states to impose restrictions on payment of prescription drugs through Preauthorization (PA) and preferred drug lists (PDL).

Prescription drugs purchased at a nonparticipating Pharmacy are not a benefit of this Evidence of Coverage. Participants will be responsible for payment of drugs purchased at a non-participating Pharmacy.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

DEFINITIONS BRAND-NAME

The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

DRUG EFFICACY STUDY INDEX (DESI) OR "LESS-THAN-EFFECTIVE-DRUGS"

An index that measures one drug against a clinical response criteria. If the index is low, the drug is classified as less-than-effective.

DRUG UTILIZATION REVIEW (DUR) PROGRAM

A quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, Medically Necessary, and not likely to result in adverse medical outcomes.

GENERIC EQUIVALENTS

Drug products are considered pharmaceutical equivalents if they contain the same active ingredients, are of the same dosage form, route of administration, and are identical in strength or concentration. Pharmaceutically equivalent drug products are formulated to contain the same amount of active ingredient in the same dosage form and to meet the same or compendial or

other applicable standards, but they may differ in characteristics such as shape, scoring configuration, release mechanisms, packaging, excipients (including colors, flavors, preservatives), expiration time, and, within certain limits, labeling (FDA *Approved Drug Products with Therapeutic Equivalence Evaluations,* 23rd Edition, March 2003).

LEGEND OR PRESCRIPTION DRUGS

Any drug(s) required by any applicable Federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.

NATIONAL DRUG CODE (NDC)

An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

NONREBATE DRUGS

Drugs manufactured or distributed by manufactures/labelers who have not signed a drug rebate agreement with the Federal Department of Health and Human Services (DHHS) or the state Department of Public Health and Human Services (DPHHS).

OBSOLETE DRUG

A drug that has been identified as obsolete by the manufacturer and is no longer available.

OBSOLETE NDC

A national drug code replaced or discontinued by the manufacturer or labeler.

OVER-THE-COUNTER (OTC) DRUG

Drugs (non-legend) that do not require a prescription before they can be dispensed.

PARTICIPATING PHARMACY

A Pharmacy which is enrolled as a Montana Health Care Programs Provider to provide Legend or Prescription Drugs to Participants and has agreed to accept specified reimbursement rates.

POINT-OF-SALE (POS)

A Pharmacy claims processing system capable of adjudicating claims online.

PREFERRED DRUG LIST (PDL)

A list of clinically effective medications from selected classes for which the Department will allow payment without restriction.

PRESCRIPTION ORDER OR REFILL

The directive to dispense a Legend or Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

PREAUTHORIZATION

Approval in advance to obtain certain prescribed medications, prior to dispensing, using guidelines approved by the Department.

TERMINATED DRUG PRODUCT

A product whose shelf life expiration date has been met, per manufacturer or CMS notification.

BENEFITS

The Department provides coverage for Prescription Drug Products if all of the following conditions are met:

1. It is Medically Necessary;
2. If it is obtained through a Participating Pharmacy;
3. It is provided while the person is a Participant; and
4. It is considered an eligible Prescription Drug Product.
5. It is prescribed by a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the Medicaid program

COVERED DRUGS

1. Legend and covered outpatient drugs as described in 42 USC 1396r-8, subject to the PDL and PA requirements.

2. The following **prescribed** over-the-counter (OTC) products manufactured by companies who have signed a Federal rebate agreement:
   - Aspirin
   - Insulin
   - Laxatives
   - Antacids
   - Head lice treatment
   - H2 antagonist GI products
   - Non-sedating antihistamines
   - Diphenhydramine
   - Proton pump inhibitors
   - OTC nicotine patches with Preauthorization
   - OTC contraceptive drugs
   - Ketotifin ophthalmic solution
   - Pyridoxine
   - Doxylamine
   - Steroid nasal sprays
   - Benzoyl peroxide

3. Compounded prescriptions

4. Contraceptive supplies and devices

5. Federal law allows states the discretion to cover certain medications listed in 42 USC 1396r-8, it has been determined that the following medications are covered:
   - Barbiturates only when used for specific conditions.
   - Prescription cough and cold medications

6. Prescription vitamins and minerals will be granted Preauthorization when indicated for the treatment of an appropriate diagnosis

NONCOVERED DRUGS

1. Drugs supplied by drug manufacturers who have **not** entered into a Federal drug rebate agreement.

2. Drugs supplied by other public agencies such as the United States Veterans Administration, United States Department of Health and Human Services, local health departments, etc.

3. Drugs prescribed:
   - To promote fertility
   - For erectile dysfunction
   - For weight reduction
   - For cosmetic purposes or hair growth

4. For an indication that is not medically accepted as determined by the Department in consultation with federal guidelines, DUR Board, or the Department medical and Pharmacy consultants.

5. Drugs designated as “less-than-effective” (DESI drugs), or which are identical, similar, or related to such drugs.

6. Drugs that are Experimental, Investigational, or of unproven efficacy or safety.

7. Free pharmaceutical samples.

8. Obsolete National Drug Code (NDC).

9. Terminated drug products.

10. Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:
    - Inpatient Hospital setting
    - Hospice services
    - Outpatient Hospital services emergency room visit
    - Other laboratory and x-ray services
    - Renal dialysis
    - Incarceration

11. Any of the following drugs:
    - Outpatient nonprescription drugs (except those OTC products previously listed)
    - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

12. Medical supplies (non-drug items) are not covered under the prescription drug program.
    Exception:
    - Contraceptive supplies and devices

PREAUTHORIZATION

Certain Prescription Drug Products require Preauthorization to be covered by the Department at the time of purchase. Preauthorization procedures require the Participant's physician to provide documentation to the Department that the prescription drug is Medically Necessary. Preauthorization may be initiated by the Participant's physician or the dispensing pharmacist. If these products are not prior authorized before being dispensed the claim will deny. The Department may delegate the Preauthorization function, but it retains the final discretionary authority regarding coverage under the HELP Coverage Group.

DISPENSING LIMITATIONS

1. Drugs are limited to a 34-day supply except for the following specific package sizes:
    - Seasonale® 91-day supply
    - Poly-vi-Flor® (and generics with or without iron) 50- to 100-day supply
    - Depo-Provera® 90-day supply
    - Vitamin B-12 injections 90-day supply
    - Maintenance supplies

    The Drug Utilization Review Board has recommended the following drug classes be considered for **maintenance supplies** (examples in parentheses):

Drug Classes Considered for Maintenance Supplies				
Heart Disease	**Diabetes Medications**	**Blood Pressure**	**Women's Health**	**Thyroid**
Digitalis glycosides (digoxin, lanoxin)	Insulin release stimulant type (glipizide)	Hypotensive, vasodilators (prasozin)	Folic acid preparations	Thyroid hormones (levothyroxine)
Antiarrythmics (quinidine)	Biguanides (metformin)	Hypotensive, sympatholytic (clonidine)	Prenatal vitamins	
Potassium replacement	Alpha-glucosidase inhibitors (acarbose)	ACE inhibitors (lisinopril)	Oral contraceptives	

Thiazide and related diuretics (HCTZ)	Insulin release stimulant/biguanide combo	ACE inhibitors/ diuretic combos		
Potassium sparing diuretics and combinations (spironolactone)		ACE inhibitor/ Calcium channel blocker combos		
Loop diuretics (furosemide)		Calcium Channel Blockers (diltiazem)		
		Alpha/beta adrenergic blocking agents (carvedilol)		
		Alpha adrenergic blocking agents and thiazide combos		
		Beta-adrenergic blocking agents (propranolol)		

2. No more than two prescriptions of the same drug may be dispensed in a calendar Month, except for the following:
   - Antibiotics
   - Schedule II and V drugs
   - Antineoplastic agents
   - Compounded prescriptions
   - Prescriptions for suicidal patients or patients at risk for drug abuse
   - Topical preparations

Other medications may not be dispensed in quantities greater than a 34-day supply, except where manufacturer packing cannot be reduced to a smaller quantity.

The DUR Board has set monthly limits on certain drugs. Use over these amounts requires Preauthorization.

PRESCRIPTION REFILLS

Prescriptions for non-controlled substances may be refilled after 75% of the estimated therapy days have elapsed. Prescriptions for controlled substances (CII-CV), Ultram (tramadol), Ultracet (tramadol/acetaminophen), carisoprodol, and gabapentin may be refilled after 90% of the estimated therapy days have elapsed. The POS system will deny a claim for “refill-to-soon” based on prescriptions dispensed on month-to-month usage.

A prescription may be refilled early only if the prescriber changes the dosage. The pharmacist must document any dosage change. Early refills are not granted for lost or stolen medication nor are they granted for vacation and/or travel. In any circumstance, the provider must contact the Drug Preauthorization Unit at <XXX-XXX-XXXX> to receive approval.

Section XXXV: Durable Medical Equipment (DME) and Medical Supplies

BCBSMT administers claims for DME and Medical Supplies. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

The HELP Program Coverage Group will pay for the most economical equipment or supplies that are Medically Necessary to treat a problem or physical condition; must be appropriate for use in the Participant’s home, residence, school or workplace.

1. DME does not include equipment or supplies that are useful or convenient, but are not Medically Necessary. DME includes things like oxygen equipment, wheelchairs, prosthetic limbs, and orthotics.
2. Diabetic equipment and supplies include things like: insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for the warranty period, and accessories to insulin pumps. (Please also see Section XXIII regarding Diabetic Education and Section XXXVII: Nutrition Services.)

Section XXXVI: Home Health Services

BCBSMT administers home health service claims for Covered Medical Expenses. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>. The ordering provider must submit Preauthorization to BCBSMT prior to providing services.

The HELP Program Coverage Group will pay for home health services provided by a licensed home health agency to Participants considered homebound in Participants' place of residence for the purposes of postponing or preventing institutionalization.

1. Home health services include:
   a. Skilled nursing services;
   b. Home health aide services;
   c. Physical Therapy services;
   d. Occupational Therapy services;
   e. Speech Therapy services; and
   f. Medical supplies and equipment suitable for use in the home.

2. Home health services not covered:
   a. Respite care;
   b. Participating home health agencies will be required to use a participating home infusion therapy provider who will bill the Claim Administrator directly;
   c. Compensation for daily prescriptions and oral medications will not be allowed through the home health agency; and
   d. Compensation for ~~A~~ambulance services will not be allowed through the home health agency.

Section XXXVII: Home Infusion Therapy Services

BCBSMT administers home infusion therapy services for Covered Medical Expenses. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

Home infusion therapy is a comprehensive treatment program of pharmaceutical products and clinical support services provided to participants who are living in their home, a nursing facility, or any setting other than a hospital. A physician's authorization (prescription) for home infusion therapy allows participants to avoid or leave the hospital care setting and receive medical care at home. Under the guidance of the participant's physician, the licensed home infusion therapy provider develops and implements a treatment program to meet the particular requirements of the Participant.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XXXVIII: Hospice Services

BCBSMT administers claims for hospice services and Preauthorization is required. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

The HELP Coverage Group will cover Medically Necessary hospice services from licensed providers.

1. A plan of care must be submitted to the Claim Administrator prior to providing services.
2. Hospice services must be Prior Authorized before services are provided.
3. Volunteer services are not a Covered Medical Expense.

Section XXXIX: Nutrition Services

BCBSMT administers claims for nutrition services that are Covered Medical Expenses. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

The HELP Program Coverage Group will cover nutrition counseling directly with Participants or with Participants' guardians for treatment of diabetes and obesity.

Section XL: Approved Clinical Trials
Routine Patient Costs provided in connection with an Approved Clinical Trial.

Section XLI: Indian Health Services (HIS) and Tribal Health
Members of federally recognized Indian tribes and their descendants are eligible for services provided by the IHS, an agency of the U.S. Public Health Service, Department of Health and Human Services.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/

Section XLII: Other Services

BCBSMT is the Claims Administrator for Covered Medical Expenses listed below. Participating Providers may contact BCBSMT at <XXX-XXX-XXXX>.

1. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when Participants have blood drawn and stored for their own use for a planned surgery.
2. Medically Necessary nutrition formula for Medically Necessary treatment of conditions in addition to inborn errors of metabolism.
3. Licensed professional medical services provided under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage includes the diagnosis, monitoring, and control of the disorder by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.
4. Supplies used outside of a Hospital are covered ONLY if the supplies are prescribed by a Participating Provider and Medically Necessary to treat a condition that is covered by HELP Coverage Group.

ARTICLE SIX– GENERAL EXCLUSIONS AND LIMITATIONS

All Benefits provided under this EOC are subject to the Exclusions and limitations stated hereunder. Except as specifically provided in this EOC, the HELP Program Coverage Group will not be required to provide Benefits for the following services, supplies, situations, and any related expenses:

1. Any service or supply which is:

    a. Not Medically Necessary to treat active Illness or injury;
    b. Not an accepted medical practice. (The HELP Program Coverage Group may consult with the Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice); and/or
    c. An Investigational/Experimental/Unproven Service or un-approved Clinical Trial.

2. Worker's Compensation: All services and supplies which would be provided to treat Illness or injury arising out of employment when Participants' employers are required by law to obtain coverage or have elected to be covered under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or injury even though:

    a. Coverage under the employment related government legislation provides Benefits for only a portion of the services incurred.
    b. Participants' employers have failed to obtain such coverage as required by law.

c. Participants have waived their rights to such coverage or Benefits.
d. Participants fail to file claims within the filing period allowed by law for such Benefits.
e. Participants fail to comply with any other provision of the law to obtain such coverage or Benefits.
f. Participants have elected to not be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if Participants are permitted by statute to not be covered and they effectively elect not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws (example: Independent Contractor holding a valid Independent Contractor Exemption Certificate).

This Exclusion will not apply if Participants' employers were not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

3. Other government services and supplies: Services and supplies that are paid for by the United States or any city, county, or state. This Exclusion applies to any programs of any agency or department of any government.

Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to Participants from the HELP Program Coverage Group. An example of this would be vaccines administered to HELP Program Participants by a county health provider. When such a circumstance occurs, Participants will receive an Explanation of Benefits.

4. Comprehensive school and community treatment (CSCT) services.

5. Third Party Automobile Liability. Services, supplies, and medications provided to treat any injury to the extent the Participant receives, or would be entitled to receive, Benefits under an automobile insurance policy. **Note:** Any services, supplies and medications provided by the HELP Coverage Group to treat the Participants for Accident related injuries which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

6. Third-Party Premises Liability: Services, supplies, and medications provided to treat any injury to the extent Participants receive, or would be entitled to receive Benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. **Note:** Any services, supplies and medications provided by the HELP Coverage Group to treat Participants for Accident related injuries which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

7. Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

8. Benefits for Participants incarcerated in a criminal justice institution. Participants are excluded from coverage only if they meet the definition of an inmate of a public institution as defined at 42 CFR 435.1009.

9. Any loss for which a contributing cause was commission by Participants of criminal acts, or attempts by Participants to commit felonies, or engaging in an illegal occupation.

10. Treatment for Temporomandibular Joint Dysfunction (TMJ).

11. Services and supplies related to ridge augmentation or vestibuloplasty.

12. Dental Services except as specifically included in this Evidence of Coverage.

13. Visual augmentation services including:

a. Contact lenses; or
b. Radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism).

See Article Five, Section XVI: Vision Benefits and Medical Eye Care for important information on vision Benefits, including eye glasses, provided by the HELP Coverage Group.

14. Service animals, including purchase, training, and maintenance costs.

15. Services or supplies related to cosmetic surgery, except as specifically included in this Evidence of Coverage.

16. Any drugs or supplies used for cosmetic purposes or cosmetic treatment.

17. Any additional charge for any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.

18. Private duty nursing.

19. Services for which Participants are not legally required to pay or charges that are made only because Benefits are available under this Evidence of Coverage.

20. Any services or supplies related to in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, and fertility enhancing treatment.

21. Sterilization or the reversal of an elective sterilization.

22. Abortion (except an abortion which is Medically Necessary to save the life of the mother or to terminate a pregnancy which is the result of rape or incest).

23. Foot care including but not limited to:

    a. Routine foot care;
    b. Treatment or removal of corns or callosities;
    c. Hypertrophy, hyperplasia of the skin or subcutaneous tissues; and/or
    d. Cutting or trimming of nails.

24. Services provided for Participants before their Effective Date of coverage or after Participants' coverage terminates.

25. Services and supplies related to sexual inadequacies or dysfunctions or sexual reassignment and reversal of such procedures.

26. Services or supplies relating to any of the following treatments or related procedures:

    a. Acupuncture
    b. Acupressure
    c. Biofeedback and Neurofeedback
    d. Chiropractic Services
    e. Naturopathy and naturopathic physician services
    f. Homeopathy
    g. Hypnosis
    h. Hypnotherapy
    i. Rolfing
    j. Holistic medicine
    k. Marriage counseling
    l. Religious counseling
    m. Self-help programs
    n. Stress management

27. Any services or supplies not furnished in treatment of an actual Illness or injury such as, but not limited to, insurance physicals and premarital physicals. Note: Well-child checkups, immunizations, and sport or employment physicals are covered.

28. Sanitarium care, custodial care, rest cures, or convalescent care to help Participants with daily living tasks. Examples of such care would include, but are not limited to:

    a. Walking
    b. Getting in and out of bed
    c. Bathing
    d. Dressing
    e. Feeding
    f. Using the toilet
    g. Preparing special diets
    h. Supervision of medication which:
        1. Is usually self-administered; and
        2. Does not require the continuous attention of medical personnel

29. No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, rest home, nursing home, rehabilitation facility, convalescent home or extended care facility for the types of care outlined in this Exclusion.

30. Supplements

31. Food supplements (except for those for inborn errors of metabolism and treatment of other Medically Necessary conditions).

32. All invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding or bariatric surgery (including all revisions).

33. Charges associated with health or weight loss clubs, or clinics.

34. Benefits shall not be paid for services or items provided by an entity, institute, or provider located outside of the United States.

35. Education or tutoring services, except as specifically included as a Benefit of this Evidence of Coverage.

36. Any services or supplies not provided by a Participating Provider or that were provided by a Non-Participating Provider following referral from a Participating Provider, but for which Preauthorization was not obtained before the services were received.

37. Services and supplies primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

38. Services and supplies related to Applied Behavioral Analysis (ABA).

39. Any services and supplies which are not listed as a Benefit of this Evidence of Coverage.

ARTICLE SEVEN – CLAIMS FOR BENEFITS

Section I: Claims Processing

Medical and Mental Health

In order to have Participant Benefit claims processed through the HELP Program Coverage Group, Participants' Participating Providers must submit all claims for services no later than 12 months after the date on which Participants received the services. All claims must give enough information about the services to determine whether they are covered under the EOC. The HELP Program Provider must submit all non-Pharmacy claims to the address listed on the back of Participants' ID cards. Federally Qualified Health Centers, Rural Health Clinics, Community Based Psychiatric Rehabilitation and Support facilities, and dentists must submit claims to DPHHS, PO Box 8000, Helena, MT 59604.

Pharmacy

For Pharmacy claims processing information please see the manual found at the following website: http://medicaidprovider.mt.gov/.

In addition, please refer to the NCPDP Payer Sheet located under Provider Notices on the following website:http://medicaidprovider.mt.gov/.

Section II: Preauthorization

Medical and Mental Health Claims

Preauthorization is required in order to receive some Benefits provided under this Evidence of Coverage. Listed covered Benefits in this Evidence of Coverage that require Preauthorization are noted under each covered Benefit. The appropriate Claim Administrator is identified for claim processing purposes under each covered Benefit. A request for Preauthorization must be submitted for consideration to the Claim Administrator in the following manner:

1. A written request for Preauthorization must be submitted to the applicable Claim Administrator in writing by the Participating Provider.

2. The written request should explain the proposed services being sought, the functional aspects of the service and why it is being done.

3. Any additional documentation such as study molds, x-rays, or photographs necessary for a determination should be mailed to the attention of the applicable Claim Administrator at the address listed on the back cover of this document. HELP Participant's names, addresses, and Participant numbers must be included.

The applicable Claim Administrator will review the request and all necessary supporting documentation to determine if the services are Medically Necessary. The decision will be made in accordance with the terms of this Evidence of Coverage. In no event shall a coverage determination be made more than 14 days following receipt of all documents.

A request for Preauthorization does not guarantee that Benefits are payable. Attending an appointment prior to receiving Preauthorization approval may result in the HELP Participant paying costs of a service determined to not be Medically Necessary, not covered, investigational, experimental, unproven, or performed in an inappropriate setting under this Evidence of Coverage.

Pharmacy Claims
<<BCBSMT will need DPHHS to confirm the language below.>>

Many drug products require Preauthorization (PA) **before** the pharmacist provides them to the client. For the Pharmacy drug Preauthorization process, please refer to the Pharmacy provider manual located at the following website: http://medicaidprovider.mt.gov/.

Section III: Payment for Professional and Hospital Services

1. Payment for services Participants receive from Participating Providers will be made by the Claim Administrator directly to the Provider.

2. No payment can be made by the Claim Administrator to the following:

    a. Participants, even if the payment is requested for reimbursement for services Participants paid directly to a provider or Hospital. Reimbursement may be made to Participants for transportation services according to the provision of this Evidence of Coverage.
    b. Participants and Providers jointly.
    c. Any person, firm, or corporation who paid for the services on Participants' behalf.

3. Non-Participating Providers may refuse payment for a covered service under the HELP Coverage Group. In the event a Non-Participating Provider does refuse to accept payment for a covered service under the HELP Coverage Group, the expenses will be the responsibility of Participants.

4. Benefits payable under this Evidence of Coverage are not assignable by Participants to any third party.

ARTICLE EIGHT – COMPLAINTS, APPEALS AND CONFIDENTIAL INFORMATION

Section I: Complaints

HELP Participants may file verbal or written Complaints about any aspect of service delivery provided or paid for by the HELP Coverage Group.

Section II: Appeals

Medical and Mental Health

1. First Level Appeal:

   If Participants do not agree with a denial or partial denial of a claim, Participants have 180 days from receipt of the denial to appeal the decision on the claim. Participants must write to BCBSMT and ask for a review of the claim denial. BCBSMT will acknowledge Participants' requests for appeals within 10 days of receipt of requests.

   To file a written appeal, Participants must state their issue and ask for a review of the denied claim and send it to:

   Blue Cross and Blue Shield of Montana
   Attn: Appeals and Grievances Department
   P.O. Box 27838
   Albuquerque, NM 8715-9705

   Participants will receive a written response to their appeal within 45 days of receipt. If Participants do not agree with the First Level determination, Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services.

2. Second Level Appeal:

   If Participants do not agree with the First Level determination, Participants may fax their Second- Level appeal request to (406)-444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

   Office of Fair Hearings
   Montana Department of Public Health and Human Services
   P.O. Box 202953 Helena, MT
   59620-2953

   The Office of Fair Hearings will contact Participants to conduct an impartial administrative hearing and/or a Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Pharmacy

1. First Level Appeal:

   If Participants do not agree with a denial or partial denial of a claim, Participants have 180 days from receipt of the denial to appeal the determination made. To request an Administrative Review, the request must be in writing, must state in detail all objections, and must include any substantiating documents and information which Participants wish the Department to consider in the Administrative Review. The request must be mailed or delivered to:

   Montana DPHHS

Attn: Pharmacy Program Officer 111 N.
Sanders
PO Box 4210
Helena, MT 59620-4210

Once the Administrative Review has been completed Participants will receive a letter outlining the Departments decision. Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services Office of Fair Hearings.

2. Second Level Appeal:

If Participants do not agree with the First Level determination, Participants may fax their Second Level appeal request to (406)-444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

Office of Fair Hearings
Montana Department of Public Health and Human Services
P.O. Box 202953 Helena, MT
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The Office of Fair Hearings will contact Participants to conduct an impartial Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district c o u r t .

Section III: Confidential Information and Records

1. Disclosure of a Participant's Medical Information – Medical documentation obtained by the Department regarding a Participant's health history, condition, or treatment is strictly confidential and may not be released without Participants' written authorization; however, the Department reserves the right to release such information without Participants' written authorization in the following instances:

   a. When such information is requested by Peer and Utilization Review Board, or by the HELP Coverage Group's medical and/or Dental consultants as required for accurate Benefit determination.
   b. Information is required under a judicial or administrative subpoena.
   c. The Office of the Insurance Commissioner of the State of Montana requests such information.
   d. Information is required for Workers' Compensation proceedings.

   Additional information may be found in the Notice of Privacy Practices for HELP Participants brochure which is provided in the enrollment package for all new eligible Participants. A copy may be requested by calling the Claim Administrator at <XXX-XXX-XXXX>.

2. Release of medically related information -- Participants accept this Evidence of Coverage under the following conditions:

   a. Participants authorize all Providers of health care services or supplies, including medical, Hospital, Dental, and vision, to furnish to the HELP Coverage Group any medically related information pertaining to any Illness, injury, service, or supply for which Benefits are claimed under this Evidence of Coverage for the purposes of Benefit determination.

   b. Participants waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies, including medical, Hospital, Dental, and/or vision, from disclosing or testifying such information.

ARTICLE NINE – OUT-OF-AREA SERVICES – THE BLUECARD® PROGRAM –

Section I: Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue

Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Member obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Member will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, the Member may obtain care from non-participating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

Section II: BlueCard® Program

Under the BlueCard® Program, when a Member incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever the Member incurs Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Medical Expenses is calculated based on the lower of:

- The billed covered charges for the Member’s covered services; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Member’s healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member’s healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Member’s claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Member’s calculation. If any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Member’s liability for any Covered Medical Expenses according to applicable law.

Non-Participating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

1. Member Liability Calculation

   When the Member incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by non-participating healthcare providers, the amount the Member pays for such services will generally be based on either the Host Blue’s non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

2. Exceptions

   In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as billed covered charges, the payment Blue Cross and Blue Shield of Montana would make if the

healthcare services had been obtained within the Blue Cross and Blue Shield of Montana service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Blue Cross and Blue Shield of Montana will pay for services rendered by non-participating healthcare providers. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

Section III: Participant Responsibility

Before You receive Montana Health and Economics Livelihood Partnership Program Benefits outside the geographic area that Blue Cross and Blue Shield of Montana serves:

- Contact Blue Cross and Blue Shield of Montana and determine whether the provider You request to see is a Host Plan Participating Provider. You may be responsible for payment of Benefits received by a Non-Participating Provider.
- Contact Blue Cross and Blue Shield of Montana and arrange for Preauthorization with your HELP Participating Provider before scheduling and receiving out-of-state services.

HELP Members who have copayments are responsible for paying applicable copayments to BlueCard Program Participating Providers.

ARTICLE TEN – EVIDENCE OF COVERAGE – GENERAL PROVISIONS

Section I: Department Powers and Duties

The Department shall have total and exclusive responsibility to control, operate, manage, and administer the HELP Coverage Group in accordance with its terms. The Department shall have all the authority that may be necessary or helpful to discharge those responsibilities with respect to the HELP Coverage Group. Without limiting the generality of the preceding sentence, the Department shall have the exclusive right: to interpret the HELP Coverage Group; to determine eligibility for coverage under the HELP Coverage Group; to construe any ambiguous provisions of the HELP Coverage Group; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the HELP Coverage Group.

The Department shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the HELP Coverage Group, including, without limitation, the construction of the terms of the HELP Coverage Group, and the determination of eligibility for coverage and Benefits. The decisions of the Department shall be conclusive and binding upon all persons having or claiming to have any right or interest in or under the HELP Coverage Group and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Department may delegate some or all of its authority under the HELP Coverage Group, or revoke such delegation given to any person, persons, or agents provided that any such delegation or revocation of delegation is in writing.

Section II: Entire Evidence of Coverage; Changes

This Evidence of Coverage, including the Endorsements and attached or referenced papers, if any, constitutes the entire Evidence of Coverage. No change in the Evidence of Coverage is valid until made pursuant to the Section of this Article entitled “Modification of Evidence of Coverage”.

Section III: Modification of Evidence of Coverage

The Department may modify this Evidence of Coverage upon the effective date of the codification of Montana Administrative Rule 37.79.304.

Section IV: Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges,

or Benefits of any Participant covered under this Evidence of Coverage. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits may be made. Clerical errors shall not prevent administration of this Evidence of Coverage in strict accordance with its terms.

Section V: Notices Under Evidence of Coverage

Any notice required by this Evidence of Coverage shall be in writing and may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Claim Administrator. Notice to the medical and mental health Claim Administrator should be sent to Blue Cross and Blue Shield of Montana at the address listed on the back cover of this document. Notices to the Pharmacy Claim Administrator should be sent to DPHHS at PO Box 8000, Helena MT 59604. Notices are effective on the date mailed.

Section VI: Benefits Not Transferable

No person, other than a Participant is entitled to the Benefits identified under this Evidence of Coverage. This means that Participants are not allowed to transfer or assign their coverage under the HELP Coverage Group to another person.

Section VII: Validity of Evidence of Coverage

If any part, term, or provision of this Evidence of Coverage is held by the courts to be illegal or in conflict with any law, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Evidence of Coverage did not contain the particular part, term, or provision held to be invalid.

Section VIII: Execution of Papers

Participants agree to execute and deliver any documents requested by the Department which are Necessary to administer the terms of this Evidence of Coverage.

Section IX: Participants' Rights

Participants have no rights or privileges except as specifically provided in the Evidence of Coverage.

Section X: Alternate Care

The HELP Coverage Group may, at its sole discretion, make payment for medical, vision or Dental services which are not listed as a Benefit of this Evidence of Coverage. Such payments may be made only when it is determined by the Department that it is in the best interest of the HELP Coverage Group and/or Participants to make payment for alternate care.

Section XI: Civil Rights Protection for Children

Children enrolled in the HELP Coverage Group have a right to:

1. Equal Access to Services without regard to race, color, national origin, disability, age, or sexual orientation;
2. A bilingual interpreter, where necessary for effective communication;
3. Auxiliary aids to accommodate a disability; and
4. File a Complaint if the Participant believes they were treated in a discriminatory fashion. If Participants need additional information regarding these protections, please contact:

Office of Civil Rights
Departments of Health & Human Services Federal
Office Building, Room 1426
1961 Stout Street
Denver, CO 80294
Telephone: (303) 844-2024
FAX: (303) 844-2025
TDD: (303) 844-3439

Section XII: Statement of Representations

Any HELP Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Department, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. Any HELP Participant who submits bad faith claims, or facilitates bad faith claims to be submitted, misrepresents facts or attempts to perpetrate a fraud upon the Department may be subject to criminal charge or a civil action brought by the Department or the HELP Coverage Group as permitted under State or Federal laws. The Department reserves the right to take appropriate action in any instance where fraud is at issue.

Section XIII: Recovery, Reimbursement, and Subrogation

By enrollment in the HELP Coverage Group, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under the HELP Coverage Group.

1. **Right to Recover Benefits Paid in Error.** If a payment in excess of the HELP Coverage Group Benefits is made in error on behalf of Participants to which Participants are not entitled, or if a claim for a non-covered service is paid, the Claim Administrator has the right to recover the payment from any one or more of the following:

   a. Any person such payments were made to, for, or on behalf of Participants;
   b. Any insurance company; and
   c. Any other individuals or entities that received payment on behalf of Participants.

   By receipt of Benefits by Participants under the HELP Coverage Group, Participants authorize the recovery of amounts paid in error.

   The amount of Benefits paid in error may be recovered by any method that the Claim Administrator, in its sole discretion, will determine is appropriate.

2. **Reimbursement.** The HELP Coverage Group's right to reimbursement is separate from and in addition to the HELP Coverage Group's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf, generally under Third Party Liability. If the HELP Coverage Group pays Benefits for medical expenses on Participants' behalf, and another party was actually responsible or liable to pay those medical expenses, the HELP Coverage Group has the right to be reimbursed.

   Accordingly, if Participants settle, are reimbursed, or recover money by or on behalf of Participants, from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any Accident, injury, condition, or Illness for which Benefits were provided by the HELP Coverage Group, Participants agree to reimburse the HELP Coverage Group for the Benefits paid on behalf of Participants. The HELP Coverage Group shall be reimbursed, in first priority, from any money recovered from a liable third party, as a result of said Accident, injury, condition, or Illness. Reimbursement to the HELP Coverage Group will be paid first, even if Participants are not paid for all damage claims and regardless of whether the settlement, judgment or payment received is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability, or other expenses or damages.

3. **Subrogation.** The HELP Coverage Group's right to subrogation is separate from and in addition to the HELP Coverage Group's right to reimbursement. Subrogation is the right of the HELP Coverage Group to exercise Participants': rights and remedies in order to recover from third parties who are legally responsible to Participants for a loss paid by the HELP Coverage Group. This means the HELP Coverage Group can proceed through litigation or settlement in the name of Participants, with or without their consent, to recover the money paid under the HELP Coverage Group. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to Participants' Accidents, injuries, conditions, or Illnesses, which the HELP Coverage Group has paid, then the HELP Coverage Group is entitled to recover, by legal action or otherwise, the money paid; in effect the HELP Coverage Group has the right to "stand in the shoes" of Participants for whom Benefits were paid, and to take any action the Participants could have undertaken to recover the money paid.

Participants agree to subrogate to the HELP Coverage Group any and all claims, causes of action, or rights that Participants have or that may arise against any entity who has or may have caused, contributed to, or aggravated the Accident, injury, condition, or Illness for which the HELP Coverage Group has paid Benefits, and to subrogate any claims, causes of action, or rights Participants may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event Participants decide not to pursue a claim against any third party or insurer, by or on behalf of Participants, Participants will notify the HELP Coverage Group, and specifically authorize the HELP Coverage Group in its sole discretion, to sue for, compromise, or settle any such claims in Participants' names, to cooperate fully with the HELP Coverage Group in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation

a. Under the terms of the HELP Coverage Group, the Department **is not** required to pay any claims where there is evidence of liability of a third party. However, the HELP Coverage Group, in its discretion, may instruct the Claim Administrator to pay Benefits while the liability of a party other than the Participant is being legally determined.

b. If the HELP Coverage Group makes payments which Participants, or any other party on Participants' behalf, is or may be entitled to recover against any third party responsible for an Accident, injury, condition or Illness, the HELP Coverage Group has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. Participants or someone acting on behalf of Participants will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the HELP Coverage Group's right of recovery.

c. Participants will cooperate fully with the Department, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the HELP Coverage Group from any party other than Participants who are liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Department, upon request and in a timely manner, of all material facts regarding the Accident, injury, condition, or Illness; all efforts by any person to recover any such monies; provide the Department with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the HELP Coverage Group; and notifying the Department of the amount and source of any monies received from third parties as compensation or damages for any event from which the HELP Coverage Group may have a reimbursement or subrogation claim.

d. Participants will respond within ten (10) days to all inquiries of the Department regarding the status of any claim Participants may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage.

e. Participants will notify the Department of the name and address of any attorney engaged to pursue any personal injury claim on behalf of Participants.

f. Participants will not act, fail to act, or engage in any conduct directly, indirectly, personally, or through third parties, either before or after payment by the HELP Coverage Group, the result of which may prejudice or interfere with the HELP Coverage Group's rights to recovery hereunder. Participants will not conceal or attempt to conceal the fact that recovery occurred or will occur.

g. The HELP Coverage Group will not pay or be responsible, without its written consent, for any fees or costs associated with Participants pursuing claims against any third party or coverage, including, but not limited to, attorney fees or costs of litigation.

h. Monies paid by the HELP Coverage Group will be repaid in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

Section XIV Relationship Between HELP Coverage Group and Professional Providers

HELP Participating Providers are Providers who contract with the Claim Administrator to provide medical care and health services to HELP Participants. HELP Participating Providers furnishing care to Participants do so as independent contractors with the Claim Administrator. The relationship between a Participating Provider and a patient is personal, private, and confidential; the choice of a provider within the HELP Network is solely the Participants'.

Under the laws of Montana, the Claim Administrator cannot be licensed to practice medicine or surgery, and the Claim Administrator does not assume to do so.

Neither the Department nor the Claim Administrator are responsible or liable for the negligence, wrongful acts, or omissions of any Participating Provider, employee, or Participant providing or receiving services. Neither the HELP Coverage Group nor the Claim Administrator is liable for services or facilities which are not available to Participants for any reason.

Neither the Department or the Claim Administrator are liable for cost of services received by Participants that are not covered by this Evidence of Coverage, are not provided by a Participating Provider, are received without Preauthorization approval, or are specifically excluded under any provision of this Evidence of Coverage.

Section XV: When Participants Move Out of State

If Participants move from Montana, they will no longer be eligible for coverage under the HELP Coverage Group. Participants will be responsible for any services received from out-of-state medical Providers. Returned mail with out-of-state forwarding addresses shall be considered conclusive evidence that Participants have moved out of state and Participants will be disenrolled from the HELP Coverage Group.

Section XVI: Authority of the Department

The Department has the authority to interpret uncertain terms and to determine all questions arising in the administration, interpretation, and application of the HELP Coverage Group, giving full consideration to all evidence reasonably available to it. All such determinations are final, conclusive, and binding except to the extent they are appealed under the claims procedure.

Section XVII: Blue Cross and Blue Shield of Montana is an Independent Corporation

Blue Cross and Blue Shield of Montana is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting Blue Cross and Blue Shield of Montana to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association.

The Participant further acknowledges and agrees that the Participant has not entered into this Evidence of Coverage based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Participant for any of Blue Cross and Blue Shield of Montana's obligations to the Participant created under this Evidence of Coverage. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under other provisions of this Evidence of Coverage

Section XVIII: DPHHS is the Fiscal Agent for the Department

DPHHS is the Fiscal Agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.